



**State of Tennessee
Department of Health
Health Related Boards
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, Tennessee 37247-1010**
(Local) (615) 532-3202 or (Toll Free) 1-800-778-4123
www.tennessee.gov

Licensed Clinical Pastoral Therapist Application

Dear Clinical Pastoral Therapist:

This packet is for Clinical Pastoral Therapist who are applying for a Licensed Clinical Pastoral Therapist license. The requirements for this license are detailed in the enclosed packet of materials. It is very important that you read the instructions, and statute 63-22-206, to ensure your application is complete.

All documents submitted to the Board become part of your file and are not returnable or transferable. Your application will be reviewed for completeness and you will be notified of the status of your application.

Please be aware that the review for completeness does not indicate whether the applicant is accepted as a candidate for licensure. Acceptable for licensure is a Board decision; not an administrative staff decision.

A non-refundable application fee of \$25.00 must accompany the application. The personal check or money order is to be made payable to the "State of Tennessee".

Please understand that it is the responsibility of all applicants and licensees to notify the board office whenever a change of name or mailing address occurs. Notification needs to be in writing and please reference your profession and the board in your correspondence. A change of name request must be notarized and state the reason for the change (i.e., marriage, divorce, etc.).

To ensure timely receipt of materials, all information is to be addressed as follows:

**Health Related Boards
Licensed Clinical Pastoral Therapist
First Floor, Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37241-1010**



001	25.00
3144 - 001	200.00
006	<u>10.00</u>
	210.00

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425 Fifth Avenue North
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Licensed Clinical Pastoral Therapist Application
Grandfathering Provision

1. Name _____
Last First Middle Maiden
2. Mailing Address (Circle one) (This address will be published on license verification web page.)
Practice or Residence

3. Social Security Number _____
4. Date of Birth _____
Month/ Day/ Year
5. Sex _____ Male _____ Female (For statistical purposes only.)
6. Telephone Numbers Home (_____) _____
Work (_____) _____
Fax (_____) _____
7. E-Mail Address _____
8. Current License Number _____

9. Please check one:

- _____ I attest I hold a current certification that is not suspended or revoked by the board.
- _____ I attest that I have completed the requirements as set forth in Rule 0450-3.04 governing Clinical Pastoral Therapist.
- _____ I attest and can show documentation that I have a current active status as a fellow or diplomate of AAPC and being actively engaged in the practice of pastoral psychotherapy for at least five (5) years prior to January 2003. (Rule 0450-3-.042b)
- _____ I attest that I have received a graduate theological degree from a recognized educational institution and being currently licensed in Tennessee as a Psychologist designated as a health service provider, a professional counselor designated as a mental health service provider, a marital and family therapist, a clinical social worker or an alcohol and drug abuse counselor, and, in addition, document being actively engaged in the practice of clinical pastoral therapy for at least five (5) years prior to January 1, 2003. (Rule 0450-3-.04(3))
- _____ I hold a current CPT and seeking the upgrade from certified to licensed. (Please remit \$25.00 for licensure duplication)

	Yes *	No
10. Have you ever had a license or certificate for the practice of any profession, including Pastoral Therapy, revoked, suspended, placed on probation or restrictions, or received a letter of reprimand?	_____	_____
11. Have you ever been denied a license or certificate to practice pastoral therapy?	_____	_____
12. Have you ever been convicted of a felony?	_____	_____
13. Have you ever been convicted of drunkenness or violation of the narcotic laws?	_____	_____
14. Have you ever been convicted for any offense involving moral turpitude?	_____	_____
15. Have you ever been charged with an ethics violation by any professional or scientific society?	_____	_____

16. Have you ever had your membership in any professional or scientific organization revoked or suspended for any reason other than nonpayment of dues? _____
17. Have you ever had clinical or staff privileges revoked or suspended? _____
- 18.* Have you ever had professional liability insurance canceled? _____

* On a separate sheet provide details relevant to any "yes" response. Please note relevant dates.

I HEREBY AUTHORIZE RELEASE, USE AND DISCLOSURE OF OTHERWISE HIPAA PROTECTED HEALTH INFORMATION TO THE LIMITED EXTENT NECESSARY FOR MY APPLICATION TO RECEIVE FULL CONSIDERATION UP TO AND INCLUDING DISCUSSION IN A PUBLIC FORUM SHOULD THAT BECOME NECESSARY.

Applicant Signature

Sworn to and subscribed before me this _____ day of _____, 20__.

Notary Public

Date

My Commission Expires on _____

SO/G5014021/CPT



TENNESSEE DEPARTMENT OF HEALTH

MANDATORY PRACTITIONER PROFILE QUESTIONNAIRE FOR LICENSED HEALTH CARE PROVIDERS

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. §§ 63-51-101, et seq., requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health, and is requested in this questionnaire. From the information submitted, the Department compiles practitioner profiles which the law requires to be made available to the public via the World Wide Web and our toll-free telephone line. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information may result in a delay or denial of your licensure application and/or may result in disciplinary action against your license.

A blank copy of the profile questionnaire may be obtained from the following web site address: <http://tennessee.gov/health>. Then select "Forms and Publications," then "Consumer Right-To-Know," then "Mandatory Practitioner Profile Questionnaire for Licensed Health Care Providers."

INSTRUCTIONS

QUESTIONNAIRE DEADLINE The provider must complete and submit the questionnaire before a license will be granted. Providers who have completed a similar questionnaire for another state's licensing board are, nevertheless, required to complete and submit this form.

COMPLETING THE QUESTIONNAIRE Complete the questionnaire by printing neatly in block letters in ball point pen or by typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.** If you need further instruction, contact your profession's licensing board by calling (615) 532-3202 or by calling toll free at (800) 778-4123.

SUBMITTING THE QUESTIONNAIRE Mail the completed profile questionnaire to:

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place, MetroCenter
Nashville, TN 37243

- ▶ **Do not return pages 1 through 4 with the questionnaire to the department**
- ▶ **Keep a copy of the questionnaire for your records.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete Part I, noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Primary Practice Address: Complete the practice address (if applicable). If your practice address is also your home address, you should know the Department is prohibited from placing your home address on the Internet without your request to do so. There is a box to check in Part I to request this. Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a “yes” answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. The definition for “hospital” can be found at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate and accept as a provider, if any. If there are more than five (5), please enclose an attachment.

VII. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, frauds, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions B and C in Part VII in their entirety before answering those questions.

VIII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

IX. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19, 1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE FOLLOWING AMOUNTS ARE NOT REQUIRED TO BE SUBMITTED.

- A) For Medical Doctors and Osteopathic Physicians, judgments or settlements below \$75,000 are not required to be submitted.
- B) For Chiropractors, judgments or settlements below \$50,000 are not required to be submitted.
- C) For Dentists, judgments or settlements below \$25,000 are not required to be submitted.
- D) For all other professions, judgments or settlements below \$10,000 are not required to be submitted.

Pending malpractice claims are not required to be reported unless/until final adjudication against you.

X. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required.

Practitioner's Name _____ License # _____
Profession _____

**HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE, METROCENTER
NASHVILLE, TENNESSEE 37243**

I. PRACTITIONER DATA

- A. PROFESSIONAL LICENSE NUMBER: _____ PROFESSION: _____
B. SOCIAL SECURITY NUMBER: _____ (This will not be published as part of the profile or website).

- C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

(LAST) (FIRST) (MIDDLE)
(IF APPLICABLE)

FORMER NAME(S):

(LAST) (FIRST) (MIDDLE)

(LAST) (FIRST) (MIDDLE)

- D. PRIMARY PRACTICE ADDRESS:

(PRACTICE NAME)

(STREET NUMBER AND NAME)

(CITY)

(STATE)

(ZIP CODE)

☐ Check here if
your primary practice
address is your
home address and
you want it to be
published as part of
the profile and on
the web site.

- E. E-MAIL ADDRESS _____
Your e-mail address will be published unless you elect not to by checking here.

☐

- F. WEB PAGE ADDRESS _____
Your web page address will be published unless you elect not to by checking here.

☐

- G. TELEPHONE: (____) _____
Your telephone number will be published unless you elect not to by checking here.

☐

- H. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.

1. _____ 2. _____

- I. SUPERVISING PHYSICIAN, If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:

1. _____

2. _____

Practitioner's Name _____ License # _____
 Profession _____

II. GRADUATE/ POSTGRADUATE MEDICAL EDUCATION AND TRAINING

- A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

- B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE,COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ License # _____
 Profession _____

III. SPECIALTY BOARD CERTIFICATIONS:

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) YES ☐ NO ☐

(Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ☐ NO ☐

If "YES", list the title of the appointment, name(s) and city/state of institution(s).
 (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(9)) YES ☐ NO ☐

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

Name of Hospital	City/State
1.	
2.	
3.	
4.	
5.	

Practitioner's Name _____ License # _____
 Profession _____

B. Do you currently participate in and accept any TennCare plan(s) as a provider? YES ☐ NO ☐
 If "YES", list each plan in which you currently participate or accept as a provider: (Authority: T.C.A. § 63-51-105(a)(16))

Name of TennCare Plan

1. _____
2. _____
3. _____
4. _____
5. _____

VII. FINAL DISCIPLINARY ACTION (See Instructions):

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8))
 YES ☐ NO ☐

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

AGENCY NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES <input type="checkbox"/> NO <input type="checkbox"/>			
2. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. _____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES <input type="checkbox"/> NO <input type="checkbox"/>			

Practitioner's Name _____ License # _____
Profession _____

- B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted or reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-51-105(a)(4))
YES ☐ NO ☐

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.	_____ _____ _____	_____	_____ _____ _____	_____ _____ _____
	IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	_____ _____ _____	_____	_____ _____ _____	_____ _____ _____
	IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	_____ _____ _____	_____	_____ _____ _____	_____ _____ _____
	IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)			YES <input type="checkbox"/> NO <input type="checkbox"/>

- C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by any hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A.: § 63-51-105(a)(4))
YES ☐ NO ☐

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME/ADDRESS	DATE	DESCRIPTION OF ACTION
1.	_____ _____ _____	_____	_____ _____ _____
2.	_____ _____ _____	_____	_____ _____ _____
	IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	_____ _____ _____	_____	_____ _____ _____
	IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>

Practitioner's Name _____ License# _____
Profession _____

VIII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-51-105(a)(1)) YES
☐ NO ☐

If "YES" briefly describe the offense(s):

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.	_____	_____	_____
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	_____	_____	_____
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	_____	_____	_____
	If "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal)		YES <input type="checkbox"/> NO <input type="checkbox"/>

IX. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. § 63-51-105(a)(5)) If "YES", indicate a brief description of the nature(s) of the claim, the date(s) of the claim report(s), and the amount of the judgment(s), award or settlement(s): YES ☐ NO ☐

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.	_____	_____
2.	_____	_____
3.	_____	_____

X. OPTIONAL INFORMATION:

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-51-105(a)(11))

	TITLE	PUBLICATION	DATE
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-51-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	ORGANIZATION
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. §§ 63-51-113 and/or 63-51-118.

(Signature of Provider)
G6019027

Date: _____